New England Reproductive Medicine and Surgery LLC

Illness/COVID-19 Protocol

We have created our ILLNESS/COVID-19 protocol based on CDC guidelines and the Massachusetts Department of Health in an effort to keep our patients, providers and staff safe. Please note that this protocol is subject to change.

1. Masks are appreciated, but not required.

2. If you have any symptoms of illness, prior to an in-office visit, please contact us immediately as we will advise you on the next steps as they relate to your appointment. We may need to reschedule your upcoming visit.

- If COVID positive, you are required, per CDC COVID guidelines, to quarantine until symptoms subside. ****PLEASE REFER TO CDC.GOV FOR A FULL LIST OF SYMPTOMS.****
- If COVID negative, but known exposure, please wear a mask for the safety of all patients and/or staff.

3. If you test COVID positive prior to surgery and you are:
    - **SYPMTOMATIC:**
        i. Your surgery will be cancelled for now. Once you are no longer experiencing symptoms you will need to report that to the office and your surgery then could be rescheduled in 6 weeks from that point (depending on availability).
            1. If you have already signed consents, they will need to be resigned at an in-office visit. Please see #2.
    - **ASYMPTOMATIC:**
        i. Your surgery will be rescheduled for 6 weeks from your positive test (depending on availability).
            1. If you have already signed consents, they will need to be resigned at an in-office visit. Please see #2.

Note: If you must bring someone with you to your appointment, our protocol applies to that person as well

If at any point you have questions regarding this protocol, please contact the office:

- Phone: (508) 917 – 6720
  Email: talktous@nermas.com

By signing below, I understand the above, acknowledge receipt of this document, agree to adhere to the protocol as outlined above, and understand that this protocol is subject to change.

_____ _____
Printed Name of Patient | Signer's Relationship to Patient, if other than Self

_____ _____
Signature of Patient / Guardian | Date